STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE

Policy No. DOC 4.5.13	Subject: **INTAKE/RECEPTION HEALTH SCREENING**
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3 and Attachment
Section 5: Health Care for Secure Facilities	Effective Date: July 15, 1999
Signature: /s/ Bill Slaughter, Director	Revision Date: April 18, 2006

I. POLICY

The Department of Corrections facility health care unit will identify and address the immediate health care needs of offenders in its facilities.

II. APPLICABILITY

The secure facilities that include Riverside and Pine Hills Youth Correctional Facilities, Montana State Prison, Montana Women's Prison, Treasure State Correctional Training Center, and the private and regional facilities contracted to the Department of Corrections.

III. REFERENCES

A. ACA Standards for Juvenile Correctional Facilities, 2003
B. National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003
C. DOC Policy 4.5.14, Offender Health Assessments

IV. DEFINITIONS

Mental Disorder – Any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions. The term does *not* include: addiction to drugs or alcohol, drug or alcohol intoxication, mental retardation, or epilepsy.

Health Care Providers – Licensed health care providers (e.g., physicians, nurses, psychiatrists, dentists, and mental health practitioners), including contracted or fee-for-service providers, responsible for offender health care and treatment.

V. DEPARTMENT DIRECTIVES

A. Intake/Reception Medical Procedures

Initial Health Screenings

1. All facilities will provide offenders with an initial health screening within 24 hours of their arrival to:

   a. identify and meet urgent health needs;
   b. identify and meet any known or easily identifiable health needs that require medical intervention before the offender is scheduled for an initial health assessment in accordance with *DOC Policy 4.5.14, Offender Health Assessments*; and
   c. identify and isolate offenders who appear to have contagious conditions.

2. Facility health care providers will administer a tuberculin skin test to each offender upon intake unless the offender's medical record indicates he or she has previously tested positive.

3. All facilities will complete Intake/Reception Health Screening forms (sees Section B. below) and use health screening results to determine immediate placement needs and appropriate referrals.

4. Health care providers will conduct the initial screening. Correctional staff members may be trained to conduct an abbreviated intake interview to alert health care providers to any urgent health needs.

Referrals

1. The facility will initiate referrals in the following circumstances:

   a. if offenders are unconscious, semiconscious, bleeding, or in need of urgent medical or mental health attention, referrals will be made to a community hospital for immediate treatment. Admission or return to the facility is predicated upon written medical clearance from the hospital;
   b. if offenders have a chronic disease, chronic mental illness, symptoms of communicable disease or illness, or are on chronic care medications (e.g., insulin); referrals will be made to a physician or mid-level practitioner; and
   c. when offenders arrive with medications, unless the offender has received a physical prior to admission, referrals will be made to a physician or mid-level practitioner for a medication review.

2. The facility will use the following guidelines for mental health screenings and referrals:

   a. if the offender is on psychiatric medications, refer for a medication evaluation;
   b. if the offender demonstrates difficulties on the mental status examination that are significant enough to cause immediate concern for the offender's well-being or ability to function, initiate an urgent referral to a mental health professional; and
   c. if the offender positively endorses two or more imminent danger of suicide indicators upon screening, initiate an urgent referral to a mental health professional and consider suicide monitoring.

B. Intake/Reception Health Screening Form

1. All Department facilities must utilize the standardized Intake/Reception Health Screening form and ensure that it is filed in the offender's health record (see Attachment, Sample Form)

2. All facilities will establish routing procedures for the Intake/Reception Health Screening form.

3. Youth immunization status will be completed on a separate form

VI. CLOSING

Questions concerning this policy should be directed to the Department medical director.

VII. ATTACHMENTS

Intake/Reception Health Screening Sample Form (Attachment)

MONTANA DEPARTMENT OF CORRECTIONS
INTAKE/RECEPTION HEALTH SCREENING FORM

Name: _____ Date & Time Admitted to
A0/JO Number: _____ Intake/Reception: _____
DOB: _____ Date & Time of Screening: _____

Status: _____ Previous Commitment: Yes ___ No ___ When: _____
Where: _____ County Detention: _____ How Long: _____
Temp: _____ Pulse: _____ Resp: _____ B.P.: _____ Ht: _____ Wt: _____

Visual Observation *(explain any "Yes" answers under "Remarks")*

1. Is offender unconscious or have obvious pain, bleeding, injuries, illness or other symptoms suggesting a need for emergency medical referral? Yes No
2. Is offender carrying any prescribed medication? If Yes, what? _____ Yes No
3. Is there obvious fever or other evidence of infection, e.g., cough, lethargy? Yes No
4. Is there evidence of body vermin, rashes, needle marks, jaundice, bruises, trauma marking, lesions, & etc.? Yes No
5. Does offender appear to be under the influence of, or withdrawing from, drugs, alcohol or an unknown substance? Yes No
6. Does offender's behavior or physical appearance suggest the risk of suicide or assault on staff or other offenders? Yes No
7. Is offender's mobility restricted in any way? Yes No
8. Is there any presence of body deformity? Yes No
9. Mental Status: (Circle appropriate status)
   a. Level of consciousness (alert, oriented, lethargic, comatose)
   b. Appearance and behavior (neatly groomed, disheveled, bizarre, threatening)
   c. Speech and Communication (fluent, mute, loud, rambling)
   d. Mood and Affect (depressed, flat, euphoric, normal, angry, irritable)
   e. Thought Process (normal train of thought, tangential, confused, disorganized)
   f. Thought Content (normal, strange or odd belief, suspiciousness, auditory and visual hallucinations present)

Offender Interview *(explain any "Yes" answers under "Remarks")*

1. Present Medication (if none, so state): _____
2. Allergies (if none, so state): _____
3. Ever had: diabetes, seizures, asthma, ulcers, high blood pressure, a heart condition or a psychiatric disorder? Yes No
4. On a special diet prescribed by a physician? Yes No
5. Been hospitalized or treated by a physician within the past year? Yes No
6. Been exposed to or have a contagious or communicable disease (i.e. AIDS, Hepatitis, TB, VD, etc.?) Yes No
7. Fainted recently or had a recent head injury? Yes No
8. Have any dental problems? Yes No
9. Have any other medical or mental problems you have not told me about? Yes No
10. Use alcohol? What kind? _____ How often? _____ Yes No
    How much? _____ When was the last time? _____
11. Use drugs? What kind? _____ How often? _____ Yes No
    How much? _____ When was the last time? _____
    Withdrawal symptoms? _____ Yes No

12. Any past history of infections or communicable illness, treatment or symptoms (e.g., lethargy, weakness, weight loss, loss of appetite, fever, night sweats) suggestive of such illness. Yes No
13. Past history of mental health treatment? When _____ Why Yes No _____ Where _____
14. History of suicide attempts or self mutilation? Yes No
15. Any current thoughts of suicide? Yes No
    a. If yes, does offender have a current plan? Yes No
    b. Does offender intend to act on his or her plan? Yes No
    c. Does offender state that he or she cannot remain safe until seen by a Mental Health Clinician? Yes No
16. WOMEN: Are you pregnant? Date of last menstrual period _____ Yes No

Remarks: _____

Placement Recommendation: (Circle one)
1. General population 2. Emergency treatment 3. Suicide monitoring
4. Next sick call 5. Isolation

Does the offender require any of the following referrals? (check appropriate and insert date if applicable)
Routine (all offenders will receive a physical exam or comprehensive nursing assessment within seven days)
Urgent (offenders appears in imminent danger)
Medication Referral (offenders need incoming meds renewed)

Medication referral _____

Medical:

Urgent _____
Routine _____
Medication referral _____

Dental:

Administration of PPD:

Mental Health:

Date _____
Time _____
Reading _____

Urgent _____
Routine _____
Medication referral _____

Urgent _____
Routine _____

OFFENDER HAS BEEN TOLD AND SHOWN IN WRITING HOW TO OBTAIN MEDICAL SERVICES

_____ _____
SIGNATURE *OFFENDER NAME*

copies to: